PediatriCare Associates
Pediatric and Adolescent Medicine

PATIENT NAME ______________________________ DATE OF BIRTH: ____/____/____

Screening Checklist for Contraindications for Vaccines for Children

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any questions, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Question	Yes	No
1.	Has your child had fever in the past 5 days? Does your child have cold symptoms or other signs of illness?	☐	☐
2.	Does your child have allergies to a vaccine component or latex?	☐	☐
3.	Has the child had a serious reaction to a vaccine in the past?	☐	☐
4.	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes) or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐
5.	In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐
6.	Is the teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐
7.	Do you want to see the doctor?	☐	☐

FORM COMPLETED, ***BY PARENT***:______________________________ DATE__________

FOR OFFICE USE ONLY

VACCINE(S) REVIEWED, ***BY PHYSICIAN***:______________________________ DATE__________

VACCINE(S) TO BE GIVEN:______________________________ DATE__________

VACCINE(S) GIVEN, ***BY NURSE***:______________________________ DATE__________

(updated 06/24/19)

20-20 Fair Lawn Avenue	400 Franklin Turnpike	901 Route 23 South	1225 McBride Avenue
Fair Lawn, NJ 07410	Mahwah, NJ 07430	Pompton Plains, NJ 07444	Woodland Park, NJ 07424
(201) 791-4545 FAX (201) 791-3765	(201) 529-4545 FAX (201) 529-1596	(973) 831-4545 FAX (973) 831-1527	(973) 256-4545 FAX (973) 826-8600